

# KENTUCKY EMPLOYEES HEALTH PLAN

## PY 2008

### ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

## INSURANCE COORDINATOR SECTION

 /  / 

Coverage Effective Date

   

Company Number

 /  / 

Deduction Start Date (BOEs ONLY)

Reason for Application:

☐ < New Employee  
 ☐ < Open Enrollment  
 ☐ < New Group  
 ☐ < FSA Only  
☐ < QE\*  
 ☐ < Previously Waived\*  
 ☐ < Other\*

\* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date AND a description of the Qualifying Event:

Date

Qualifying Event Description

### SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

   -   -    

Social Security Number

 /  /    

Date of Birth (MM/DD/YYYY)

#### Smoking Status (Required)

Have you  
smoked in the  
last 2 months?

☐ < Yes   ☐ < No

NAME (First, MI, Last)

Mailing Address

City, State, Zip Code

County of Residence

Country / Mail Code, if not USA

Planholder's HOME Phone Number

Planholder's WORK Phone Number

Planholder's Email Address

Hire Date

Employer Name

Work County

### SECTION II: PLAN SELECTION → If you wish to waive coverage, skip to Section V below

#### 1. Option (Check only one)

☐ < Commonwealth Essential  
☐ < Commonwealth Enhanced  
☐ < Commonwealth Premier  
☐ < Commonwealth Select

#### 2. Level of Coverage

☐ < Single  
☐ < Parent Plus  
☐ < Couple  
☐ < Family

#### 3. Cross-Reference Payment Option

(Available for Family Coverage Only)

☐ < Yes

If Yes, you must complete Sections III and IV

### SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → If you selected Single coverage, skip to Section VI

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M   F		
		M   F		
		M   F		
		M   F		
		M   F		

### SECTION IV: CROSS-REFERENCE INFORMATION → Complete ONLY if you checked Yes in Section II, box 3

Your Spouse's Company Number: (Required) <input type="text"/>	Has your spouse smoked in the last 2 months? (Required) <input type="checkbox"/> < Yes <input type="checkbox"/> < No	Is your spouse a Hazardous Duty Retiree? <input type="checkbox"/> < Yes <input type="checkbox"/> < No	Your spouse's Hire Date or Retirement Date: <input type="text"/>	Your spouse's Deduction Start Date (If BOE employee): <input type="text"/>
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### SECTION V: WAIVER → Complete this section only if you did not select coverage in Section II

Do you wish to waive your coverage and have the employer contribution of \$175 per month deposited into a Health Reimbursement Account (HRA), **if eligible?** (If not eligible, you will be set up as a **Waiver with no HRA**)

☐ < Yes

# KENTUCKY EMPLOYEES HEALTH PLAN

## ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

### PAGE 1 Instructions

#### Reason for Application

- **New Employee:** Check this box if you are a new employee.
- **Open Enrollment:** Check this box if you are filling out this application for Open Enrollment.
- **New Group:** Check this box if your employer is joining the Kentucky Employees Health Plan (KEHP) for the first time.
- **FSA Only:** Check this box if you are enrolling in a Flexible Spending Account for the first time due to a Qualifying Event (QE).
- **QE:** Check this box if you are making a change to your overage Option, as permitted by a valid QE.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a QE that allows you to select coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other QEs do not require an application and do require a Dependent Add or Drop form only. You may request a Dependent Add or Drop form from your Insurance Coordinator (IC) or you may visit [www.kehp.ky.gov](http://www.kehp.ky.gov) to print one and must provide supporting documentation, as required.
- **Other:** Check this box if none of the listed options apply. The IC must provide a date and an explanation if "Other" is selected.

**TO THE INSURANCE COORDINATOR:** Complete the information requested within the box in the top right corner of the application.

For ALL employees - Enter the effective date of coverage and the employee's company number.

For BOE employees only – Enter the Deduction Start Date.

#### SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the planholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Smoking Status, Gender, Marital Status, Planholder's HOME and WORK Phone Numbers, Planholder's Email Address, if available, Hire Date, Employer's Name and Work County. **Note:** If the smoking status flag is not checked, this application will be on Pended status until the information is provided. **The smoking status that you select during Open Enrollment or as a new employee will remain for the entire Plan Year. A change in your smoking status is NOT a qualifying event.**

#### SECTION II: PLAN SELECTION

1. **Option:** Mark the option you are selecting. For a description of each option, see the KEHP Handbook. Select only one.
2. **Level of Coverage:** Mark the level of coverage you are selecting. For a description of each level of coverage, see the KEHP Handbook. Select only one.
3. **Cross-reference Payment Option:** If you wish to elect the cross-reference payment option, check Yes and complete Sections III and IV. This payment option is only available for Family coverage. ONLY ONE application is required.

#### SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Provide the information requested for every dependent you are enrolling (including your spouse if electing the cross-reference payment option). If you need additional space, use Page 1 of another enrollment application.

Relationship Code: Enter the appropriate relationship code as follows:

- SP Spouse (your eligible spouse under a legal marriage).
- CH Child (your eligible child, step child, adopted child, foster child or your grandchild) age 0 to 23 (to enroll, a dependent must be age 23 or less and not turn 24 during the coverage year). See the KEHP Handbook for eligibility requirements and needed supporting documentation to enroll your eligible dependent children (e.i., legal guardianship is required to enroll a grandchild, etc.)
- DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, the TPA will request evidence of his/her disability annually.
- CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance).

#### SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are selecting the cross-reference payment option. Enter your spouse's company Number (required), smoking status (required), hazardous duty retiree indicator, hire date or retirement date (if applicable), and the deduction start date (only needed if the planholder elects to start a cross-reference payment option with a school board employee).

#### SECTION V: WAIVER

Complete this section ONLY IF YOU DID NOT SELECT COVERAGE in Section II. You must mark Yes if you are electing to waive health coverage for the Plan Year and direct the employer contribution of \$175 per month into an HRA, if eligible.

If you do not mark Yes in this section, you will not receive the employer contribution of \$175 per month for the Plan Year. If you are not eligible to receive the employer contribution toward an HRA, you will be set up as a Waiver with NO HRA.

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Planholder's SSN

**SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)** → Enrollment in an FSA is OPTIONAL

If you are an employee of a health department or certain quasi agencies, this section **does not apply to you**. You must contact your insurance coordinator regarding your employer's FSA enrollment process.

**Healthcare** → All amounts must be divisible by two.

The **minimum** allowable monthly contribution is \$10

The **maximum** allowable yearly contribution is \$5,000

<b>Planholder</b>  Total Employee Contribution for Plan Year _____	<b>Spouse</b> → If paying by cross-reference and spouse's FSA program is administered by the KEHP  Total Spouse Contribution for Plan Year _____
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**Dependent Care** → All amounts must be divisible by two.

**Minimum** allowable monthly contribution - \$10

**Maximum** allowable yearly contribution – based on tax filing status

Tax Filing Status:

☐ < Married, filing separately (max = \$2,500)
 ☐ < Married, filing jointly (max = \$5,000)
 ☐ < Single, head of household (max = \$5,000)

<b>Planholder</b>  Total Employee Contribution for Plan Year _____	<b>Spouse</b> → If paying by cross-reference and spouse's FSA program is administered by the KEHP  Total Spouse Contribution for Plan Year _____
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HumanaAccess<sup>SM</sup> VISA® Card

Upon enrolling in an HRA or an FSA, you will receive the HumanaAccess<sup>SM</sup> Visa® card at no cost to you.

**SECTION VII: COORDINATION OF BENEFITS**

Are you or any of your dependents listed on this application covered under another health insurance plan? ☐ < Yes ☐ < No

**SECTION VIII: AUTHORIZATION AND CERTIFICATION**

- \* I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
- \* I understand that if my spouse and I elect the cross-reference payment option, our level of coverage (Family) cannot change if one of us terminates employment, and the remaining spouse will pay the full family contribution.
- \* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
- \* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan document.
- \* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- \* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
- \* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
- \* I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Request form.
- \* I understand that enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
- \* Regarding my FSA, I understand that any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
- \* Regarding my FSA, I further understand that any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
- \* I understand that I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
- \* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
- \* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse Signature – **REQUIRED** if electing the cross-reference payment option \_\_\_\_\_

Date \_\_\_\_\_

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Employee's Insurance Coordinator Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's Insurance Coordinator Signature – **REQUIRED** if electing the cross-reference pmt. option \_\_\_\_\_

Date \_\_\_\_\_

# KENTUCKY EMPLOYEES HEALTH PLAN

## ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

### PAGE 2 Instructions

Enter the social security number of the planholder in the spaces provided on the top right hand corner of Page 2.

#### SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

- This section can only be completed by employees of state agencies, boards of education and certain quasi agencies.
- If you are an employee of a health department or certain quasi agencies, you cannot use this section to enroll in an FSA. You must contact your IC regarding your employer's FSA enrollment process and deadlines.
- Enrollment in an FSA is OPTIONAL and is completely funded from employee's funds (no employer funds are directed into an FSA). In order to direct an amount into an FSA you must enroll, either online or by completing this section (for state, board of education and certain quasi agency employees) by the deadline.
- All amounts entered in this section are yearly amounts.

#### Healthcare

**All amounts must be divisible by two.**

#### *PLANHOLDER*

**Total Employee Contribution for Plan Year:** Enter the total employee contribution amount for the entire coverage period.

#### *SPOUSE (For cross-reference payment option only)*

Complete this section with YOUR SPOUSE'S Healthcare FSA information, only if your spouse meets ALL of the following:

- He/she is a state employee, a board of education employee, or a quasi agency employee for whom the KEHP administers the FSA program;
- He/she is electing the cross-reference payment option; and
- He/she is electing to enroll in the available FSA program. Enrollment in a Flexible Spending Account is OPTIONAL.

**Total Spouse Contribution for Plan Year:** Enter the spouse's total contribution amount for the entire coverage period.

#### Dependent Care

Mark the tax filing status that applies to you (or to both of you if your spouse is eligible and is also enrolling).

#### *PLANHOLDER*

**Total Employee Contribution for Plan Year:** Enter the total employee contribution amount for the entire coverage period.

#### *SPOUSE (For cross-reference payment option only)*

**Total Spouse Contribution for Plan Year:** Enter the total contribution amount for the entire coverage period.

**HumanaAccess<sup>SM</sup> VISA<sup>®</sup> Card:** If you are eligible and elect to participate in an employer-funded HRA (for waivers or for employees selecting the Commonwealth Select Plan) or in an employee-funded FSA Program (for state agencies, boards of education and certain quasi agency employees), you will receive the HumanaAccess<sup>SM</sup> VISA<sup>®</sup> card at no cost to you. This is a free service offered to you.

#### SECTION VII: COORDINATION OF BENEFITS

Check whether or not you, or any of the dependents listed on this application, are covered under another health insurance plan.

#### SECTION VIII: AUTHORIZATION AND CERTIFICATION

- **Read each statement carefully.** After you have read and understood the statements, sign your name and enter today's date in the lines provided. If you are electing the cross-reference payment option, your spouse MUST also sign and date the application.
- Your cross-referenced spouse must have his/her insurance coordinator(IC) sign this form before you return it to your IC.
- Your cross-reference application will not be processed without the four required signatures and dates.

**REMEMBER THAT YOU HAVE THE OPTION TO ENROLL ONLINE at [www.kehp.ky.gov](http://www.kehp.ky.gov). ENROLLING ONLINE IS EASY, FAST AND SECURE. IF YOU ENROLL ONLINE, YOU WILL RECEIVE INSTANT CONFIRMATION THAT YOU HAVE ENROLLED! **PRINT AND SAVE YOUR CONFIRMATION PAGE!****